

DEPARTMENT OF HEALTH SERVICES

1744 P STREET
SACRAMENTO, CA 95814



(916) 445-1912

December 4, 1981

TO: All County Welfare Directors

Letter No. 81-55

RAMOS VS. MYERS COUNTY PROCEDURES

The attached procedures describe county welfare department responsibilities as the result of a recent court settlement (Ramos vs. Myers). Previous information regarding the court settlement was described in All County Welfare Directors Letter No. 81-45. The attached procedures must be implemented by December 15, 1981. The first notice of action mailing will start on that date.

The attached information will provide counties with:

1. County processing procedures and a summary chart of the SSI/SSP-based Medi-Cal discontinuance process.
2. A sample of each Discontinuance of SSI/SSP Medi-Cal Notice of Action, application forms and request for hearing forms.
3. A form to report statistical information on the Ramos vs. Myers process. Data to be reported is shown below.

Statistical Information

In order to determine future fiscal projections for the cost of the Ramos vs. Myers process, it is requested that counties provide the following information for January and February 1982.

1. Number of individuals who returned the MC 211 timely.
2. Number of individuals who did not return the MC 211 timely but did return the form within the same month.
3. Number of individuals granted additional months of continued no cost or state determined share-of-cost Medi-Cal as the result of delayed county eligibility determination.

The Department will collect additional data by reviewing share-of-cost cases. County welfare department case reviews will be performed by the Medi-Cal Eligibility Branch Program Consultants.

All County Welfare Directors

-2-

December 4, 1981

If you have any questions or need further information, contact your Medi-Cal Program Consultant.

Sincerely,

Original signed by

Barbara V. Carr for
Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachments

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants
Expiration Date: June 30, 1981

SSI/SSP-BASED MEDI-CAL DISCONTINUANCE SYSTEM

(RAMOS vs. MYERS)

These procedures provide county welfare departments information and detailed instructions for implementing the Ramos vs. Myers court settlement. Counties received advance notice of this settlement in All County Welfare Directors Letter No. 81-45.

I. Background

Suit was brought against the Department of Health Services in the federal U. S. District Court over the effect the discontinuance of a Supplemental Security Income/State Supplemental Payment (SSI/SSP) cash grant has on a person's Medi-Cal coverage. As a result of the suit, the court has ordered that DHS:

- A. Issue a notice of action to all persons whose SSI/SSP-based Medi-Cal has been discontinued and inform them of the actions they must take to have Medi-Cal-only eligibility determined;
- B. Mail an application for Medi-Cal-only, and a short-form version of the Medi-Cal Statement of Facts, to certain of the persons discontinued;
- C. Extend no-cost Medi-Cal eligibility, including issuing Medi-Cal cards, for the Extended Eligibility group of SSI/SSP discontinued persons, until the county determines Medi-Cal-only eligibility based on current information from the client;
- D. Determine an initial share-of-cost using income information supplied on the State Data Exchange (SDX), and issue an MC_177S for persons discontinued as the result of "excess income" until the client has supplied current information for a county determination.
- E. Identify discontinued persons who are in long-term care, so counties can contact these persons directly and help them apply for Medi-Cal-only;
- F. Afford a fair hearing to persons who wish to appeal loss of their SSI/SSP-based Medi-Cal, as long as they are entitled to appeal;
- G. Grant aid paid pending to persons who appeal loss of their SSI/SSP-based Medi-Cal in a timely fashion, as long as they are entitled to appeal.

Approximately 12,500 people are newly discontinued from SSI/SSP and SSI/SSP-based Medi-Cal each month. These individuals are identified on the SSA supplied SDX computer tapes.

Of this total, approximately 10,400 persons are discontinued monthly because of death, loss of contact, or loss of California residence. The remaining 2,100 people are potentially eligible for continued Medi-Cal coverage. Only these 2,100 people are expected to impact county welfare departments' eligibility determination processing.

II. SSI/SSP Discontinuance Process

The following chart describes the SSI/SSP Discontinuance categories and related state and county actions required.

NOTE: During the interim process, DHS will send the county duplicate copies of the notice of action sent to people in the Excess Income and Extended Eligibility categories. These duplicates are used to monitor the return of Medi-Cal applications for people in these two categories. Beginning April, 1982 DHS will discontinue this procedure and will begin production of a county register identifying the people in each of these two categories.

INTERIM SSI/SSP DISCONTINUANCE PROCESS

Category and Number in Category	State Action	Client Action Required	Taken Timely	County Action
Death; Loss of Contact; Loss of Residence 10,400/month statewide	Produce and send to Client: o Notice of Action o Notification of Right to Appeal	If SSA discontinuance was erroneous, client will contact SSA or DHS	N/A	None
Extended Eligibility 625/month statewide	Produce and send to Client: o Notice of Action o Notification of Right to Appeal o Application for Public Assistance (CA 1) o Medi-Cal Temporary Redetermination Form (MC 211) o "Extended Eligibility" Medi-Cal card for the first month under no share of cost aid code Produce and send to County: o Copy of the Notice of Action The notice contains name, address, Medi-Cal ID No., SSN, deadline for filing for continued Medi-Cal only.	Yes	Yes	o Process application (a). Note: Provide a temporary Medi-Cal card, non share of cost aid code, if county eligibility determination is not completed in time for following month(s) Medi-Cal eligibility. o Complete and mail Notice of Action discontinuing Extended Medi-Cal eligibility.
Excess Income -- Regular Share of Cost 850/month statewide	Compute initial SOC, based on income data in SDX discontinuance record Produce and send to Client: o Notice of Action o Notification of Right to Appeal o Application for Public Assistance (CA 1) o Medi-Cal Temporary Redetermination Form (MC 211) o Record of Health Care Costs -- Share of Cost (MC 177S) Produce and send to County: o Copy of Notice of Action. The notice contains name, address, Medi-Cal ID no., SSN, deadline for filing for continued Medi-Cal-only.	Yes	Yes	o Process application (a); recompute state determined share of cost. Note: Provide second month MC 177 using original state-determined share of cost if county eligibility determination is not completed in time for following month(s). o Completed and returned MC 177 -- standard processing. o Complete and mail Notice of Action discontinuing Excess Income Medi-Cal eligibility.

Category and Number in Category	State Action	Client Action Required	Client Action Taken Timely	County Action
Long-term Care	Produce and send to Client: <input type="checkbox"/> Notice of Action <input type="checkbox"/> Notification of Right to Appeal Produce and send to County: <input type="checkbox"/> Copy of Medi-Cal Long-term Care Facility Admission and Discharge Notification Form (MC 171)	No		<input type="checkbox"/> Standard LTC Outreach and Eligibility Determination
225/month statewide				
Reason other than above	Produce and send to Client: <input type="checkbox"/> Notice of Action <input type="checkbox"/> Notification of Right to Appeal <input type="checkbox"/> Application for Public Assistance (CA 1) <input type="checkbox"/> Statement of Facts for Medi-Cal (MC 210)	Yes	Yes	<input type="checkbox"/> Standard intake processing.
500/month statewide			No	<input type="checkbox"/> None
				(a) Eligibility determination is to be made based upon MC 211 unless the information is inadequate. County may request beneficiary complete an MC 210. Also, face-to-face interview will be after initial determination.

III. County Welfare Department Responsibilities

The county welfare departments' eligibility determination responsibilities under the "Ramos" settlement are identical to those required under the regular Medi-Cal determination process. Counties are responsible for accepting and processing applications, determining eligibility and share-of-cost, for providing share-of-cost forms to the beneficiary and for producing cards for Medi-Cal eligibles. Applications for Medi-Cal made by individuals in most SSI/SSP discontinued categories shall be processed according to current Medi-Cal procedures.

The court settlement requires that Medi-Cal eligibility be continued for people in the Excess Income and Extended Eligibility categories until a transfer from cash-based Medi-Cal to Medi-Cal-only is accomplished or until the county determines that the individual is ineligible. Therefore, the county must expedite processing of applications submitted by these clients.

A. County Processing of Excess Income Cases

1. Client returns MC 211 and CA 1 timely.
 - a. If the client returns the MC 211 and CA 1 timely, the county shall determine Medi-Cal eligibility and share-of-cost based upon information provided on the MC 211.
 - b. If it appears that more information is needed than appears on the MC 211, the county shall require the client to complete the Statement of Facts for Medi-Cal, MC 210. Otherwise, the beneficiary need not complete the MC 210 until annual redetermination.
 - c. If eligibility exists, the county must recompute the state determined share of cost for the month of state determined Medi-Cal-only eligibility. If necessary, reduce the state determined share-of-cost retroactively in accordance with Title 22, CAC, Sections 50565 and 50567.
 - d. Initiate notices of action for continuing eligibility/share-of-cost and decrease in state determined share-of-cost if appropriate.
 - e. Schedule and conduct the face-to-face interview within 90 days.
 - f. If information supplied in the face-to-face interview results in the client's ineligibility or change in the share-of-cost, issue the appropriate notice of action.
2. Client does not return the MC 211 and CA 1 timely.

- a. It is suggested that counties wait until the 20th of the current month to send discontinuance notice to the individual effective the end of the current month for failure to provide information.
 - b. If the client submits the CA 1 and MC 211 after the discontinuance notice has been sent but prior to the end of the current month, counties may rescind the discontinuance notice. If it appears that more information is needed than is contained on the MC 211, the county shall require the client to complete the Statement of Facts for Medi-Cal (MC 210). Otherwise, the client need not complete the MC 210 until annual redetermination.
 - c. If eligibility exists, the county must recompute the state determined share of cost for the month of state determined Medi-Cal-only eligibility. If necessary, reduce the state determined share-of-cost retroactively in accordance with Title 22, CAC, Sections 50565 and 50567.
 - d. If information identified from review of the MC 211 and from the face-to-face interview results in the client's ineligibility, or change in the share-of-cost, send appropriate notice.
3. Client returns an incomplete MC 211 and CA 1 timely.
- a. Contact the client by telephone if possible, and obtain the necessary information. Document this action in the margin on the MC 211.
 - b. Follow the regulations as provided on Title 22, CAC, Section 50165.
 - c. Continue to issue an MC 177S using the state determined share-of-cost until such time as the client provides the information or the county discontinues the individual for failure to provide necessary information.
 - d. If the information is received within a reasonable period of time, determine eligibility as described in A 1 above.
4. Client returns application timely, but the county fails to determine eligibility timely.
- a. Notify the client of the circumstances. Provide an MC 177S for the next month, using the state issued beneficiary ID number and share-of-cost shown on the duplicate copy of the state issued notice of action.
 - b. Expedite county processing of the client's application. The county must continue the original state determined share-of-cost Medi-Cal coverage until the eligibility determination is made and proper notice is given.

Beginning date of eligibility for county determined Medi-Cal-only eligibility shall be the first of the month following the state determined share-of-cost month.

Example: Discontinuance of SSI/SSP-based Medi-Cal	December 31, 1981
Month of state determined Medi-Cal share-of-cost eligibility	January 1982
First month of county determined eligibility	February 1982

Exception: If the county's recomputation of the state-computed share-of-cost results in a lower share-of-cost for that past month, then that month is the first month of county determined eligibility.

5. MC 177S Processing

Counties shall process the state issued MC 177S according to existing procedures regardless of if or when the MC 211 and CA 1 are submitted.

B. County Processing of Long-Term Care (LTC) Cases

1. Use the county copy of the Medi-Cal Long-Term Care Facility Admission and Discharge Form (MC 171) to identify LTC discontinuance cases.
2. Contact such persons in the LTC facilities within 30 days and assist them with completion of a Medi-Cal-only application, in accordance with Title 22, CAC, Section 50147.

C. County Processing of Extended Eligibility Cases

The county will follow the same procedures as described for Excess Income cases in A 1 through 4 above with the following exceptions:

1. Since the individual is discontinued based upon excess resources or, for children under 21, loss of disability linkage rather than excess income, no MC 177S is included for these individuals pending county continuing eligibility determination.
2. Some of the people in this category were discontinued by SSA because of excess income. Since the SDX record did not contain valid or updated information, no share-of-cost could be determined. Therefore, if the beneficiary returns an MC 211 and CA 1 by the fifth of the current month, the county must continue no-cost Medi-Cal coverage until the county eligibility determination and share-of-cost computation is made and proper notice is given.
3. If county action on the client's application is not timely, the county must prepare and issue a temporary Medi-Cal card, MC 301, using the beneficiary ID number printed on the notice of action. Other pertinent information must be taken from the SDX record.

D. County Processing of All "Other" Discontinued Categories

Persons who receive an MC 210 and CA 1 as part of the notification process will be responsible for returning that form to the county if they want their eligibility determined under another program. Upon receipt, counties shall process these forms using regular intake procedures.

IV. Issuance of Medi-Cal ID Cards/Numbers

As described above, in some situations the county will be responsible for preparing and issuing Medi-Cal cards. The following procedures shall be followed when generating such cards.

1. Temporary Medi-Cal cards (MC 301) must be used. Neither CID or MEDS is capable of generating these cards at present through the state centralized process. County welfare departments which have computer capability of generating temporary Medi-Cal cards may do so providing the procedures listed below are followed
2. All information needed to prepare a Medi-Cal card, with the exception of the Medi-Cal ID number, shall be taken from the county SDX file. That information includes:

Name of Beneficiary
Address
Date of Birth
Sex
Other Coverage
HIC, RR or SSN
Medicare Status

Cards shall be generated using current temporary card issuance procedures as described in the Medi-Cal Eligibility Manual Procedures Section 14A.

3. The Medi-Cal ID number will consist of the county code (two digits) aid code (two digits) a constant "9" indicator (one digit) and the individual's Social Security Number (SSN) (nine digits). (59-14-9-123456789)

The following aid codes shall be assigned to persons receiving continued Medi-Cal until a county determination and county case number is assigned.

<u>Category</u>	<u>Extended Eligibles -- No Share of Cost</u>	<u>Excess Income -- Share of Cost</u>
Aged	14	17
Blind --	24	27
Disabled	64	67

V. Fair Hearing Process

A. Fair Hearing Requests

Those people who wish to appeal their SSI/SSP-based Medi-Cal discontinuance must either send a request for a state hearing to the Office of Chief Referee or must contact Public Inquiry and Response Unit at DSS. The county welfare department will not be involved in such appeals and should refer those clients to DSS if they contact the county.

B. Aid Paid Pending

1. State Action

When DHS is notified by DSS of a timely appeal of a "Ramos" discontinuance, aid paid pending will be granted. Zero share-of-cost Medi-Cal cards, as described in Section IV above, will be issued by DHS pending the fair hearings or fair hearing decision.

DHS will notify the county immediately of all recipients granted aid paid pending status, as described below. The aid paid pending notification will be a computer listing, including name, address, Medi-Cal ID number and SSN of all people who are:

- a. Currently receiving aid paid pending;
- b. Newly granted aid paid pending;
- c. Discontinued from aid paid pending.

The listing will be sent at least once a month.

2. County Action

The county shall take no action on any application submitted by a person currently receiving aid paid pending. Once aid paid pending terminates, DHS will send the client a second application (MC 211) together with instructions for applying for Medi-Cal-only.

The county will be notified of such individuals. County processing of the new MC 211 will be done the same way as for those people who are newly discontinued from SSI/SSP Medi-Cal.

The county shall issue replacement Medi-Cal cards or additional POE labels upon request for individuals in aid paid pending status. Name, Medi-Cal ID number and SSN shall be taken from the aid paid pending listing. Other necessary information shall be taken from the county SDX.

C. Fair Hearing Requests Based Upon County Actions

Fair hearing requests based upon county discontinuance shall be processed using standard fair hearing procedures.

Clients who appeal the county discontinuance timely will be eligible for aid paid pending. The county shall continue the eligibility status determined by the state until a decision has been rendered or the State Hearing Officer orders cessation of aid paid pending.

The county will issue "no-cost" Medi-Cal cards to Extended Eligibles or an MC 177S to those Excess Income Eligibles using the State issued Medi-Cal ID numbers as described in Section IV above.

DESCRIPTION OF NOTICE ELEMENTS -

The following lettered items correspond to the lettered areas in the model notices and describe the information that is to be added when the notice records are produced.

A - Notice Preparation Date

The month, day, and year the notice records are produced.

B - Beneficiary Name and Address

The first line of this entry will be the Sequence Number, which consists of a two-character alpha code identifying the type of notice being produced and a five-digit sequence number. This will be positioned just above the right-most edge of the target area provided in the model notices. The remaining five lines will be the name and address data included in the not eligibles input record.

C - The Social Security Account Number in the not eligibles record.

D - The "New Beneficiary Identification Number" present in the input record.

E - The last day (including year) of the current calendar month.

F - Share-of-Cost amount present in the input record.

G - The calendar month and year following the current month.

H - County Welfare Department Address

The address of the welfare department in the county in which the beneficiary is eligible for benefits is to be included in the Excess Income, Extended Medi-Cal Eligibility, and "Other" notices.

I - The fifth day of the calendar month and year following the current calendar month.

J - The last day of the calendar month and year following the current calendar month.

K - The current calendar month and year.

NOTICE PREPARATION DATE:
** A **

MEDI-CAL
NOTICE OF ACTION

DISCONTINUANCE OF SSI/SSP MEDICAL --
EXCESS INCOME

*** B ***

Social Security Number:
** C **

Beneficiary ID Number:
** D **

The Social Security Administration (SSA) has notified us that you are no longer eligible to receive a Supplementary Security Income/State Supplementary Payment (SSI/SSP) gold check. Because of this, you will not be eligible for an SSI/SSP Medi-Cal card after
 ** E **.

The regulations which require this action are California Administrative Code, Title 22, Sections 50227 and 50703.

Even though you are no longer eligible for an SSI/SSP Medi-Cal card, it appears from the information we have that you are still eligible for Medi-Cal benefits under another category. Because the income available to you has increased, you will have a "share of cost". This means that you must pay for part of your medical cost each month and then Medi-Cal will pay the rest. YOUR SHARE OF COST IS \$ *F*.

Attached is a Record of Health Care Costs for ____** G **____. The box marked "Share of Cost" also shows the amount we have determined you must pay for your medical care in that month. If you need medical care, take this form with you and have the medical provider complete it. Instructions for completion of the form are on the back of the form. YOU WILL RECEIVE THIS FORM ONLY FOR THE MONTH OF ____** G **____ unless you are interested in continuing Medi-Cal benefits and take the action specified below. Upon completion of the MC177, you must send or take the form to the address indicated below.

IF YOU ARE INTERESTED IN CONTINUING TO RECEIVE MEDI-CAL BENEFITS, YOU MUST COMPLETE THE APPLICATION AND MEDI-CAL TEMPORARY REDETERMINATION FORMS THAT ARE ATTACHED. Mail them IMMEDIATELY to the following address:

**** H ****

If the Application and Medi-Cal Temporary Redetermination forms are received by
 ** I ** and the information you provide on the forms is complete, the county will
determine your continuing eligibility immediately.

The county will contact you to set up an appointment for a required face-to-face interview with your county eligibility worker after your continuing Medi-Cal only eligibility is determined for the first time.

MEDI-CAL NOTICE OF ACTION
DISCONTINUANCE OF SSI/SSP MEDI-CAL -- EXCESS INCOME
Page 2

If the forms do not provide complete information, the county will contact you for the necessary information. If you do not provide it, your Medi-Cal eligibility will end.

If you have questions on how to complete the forms or if you need help with them, contact the county at the address or phone number listed above.

If the Application and Medi-Cal Temporary Redetermination forms are not returned by the date stated above, the county will not be able to determine your share of cost and you will not have an opportunity to meet that share of cost and receive a Medi-Cal card after ** J ** . If you want Medi-Cal again, you will have to make an application at the county welfare department.

Keep this letter to show the county welfare department. It will help them to determine your Medi-Cal status.

If you are still receiving an SSI/SSP gold check, you should contact your county welfare department. The county will verify with SSA that you should continue to get an SSI/SSP Medi-Cal card and will then give you a card for the current month.

PLEASE READ THE ENCLOSED REQUEST FOR FAIR HEARING

**MEDI-CAL
NOTICE OF ACTION**

**DISCONTINUANCE OF
SSI/SSP MEDI-CAL
PERSONS IN LONG-
TERM CARE**

The Social Security Administration (SSA) has notified us that you are a patient in a hospital or nursing home receiving long-term care and that you are no longer eligible to receive a Supplemental Security Income/State Supplementary Payment (SSI/SSP) gold check. This means that you are no longer eligible for Medi-Cal as an SSI/SSP recipient. You will no longer receive an SSI/SSP Medi-Cal card after _____.

The regulations that require this action are California Administrative Code, Title 22, Sections 50227 and 50703.

Even though you are no longer eligible for an SSI/SSP Medi-Cal card, it appears from the information we have that you are still eligible for Medi-Cal benefits under another category. Because you are in long-term care, you will have to pay all of your income in excess of \$25 (and if applicable, an amount necessary to meet the needs of your spouse and/or minor children) towards the cost of your care. A representative of the county welfare department will be contacting you or the person who handles your financial affairs by _____. This representative will explain to you or your representative what must be done in order to continue your Medi-Cal eligibility.

Keep this letter to show the county welfare department. It will help them to determine your Medi-Cal status. If you are not contacted by the county welfare department by _____ please contact them at the following address to ensure that your Medi-Cal eligibility will continue.

If you are still receiving an SSI/SSP gold check, you should contact your county welfare department. The county will verify with SSA that you should continue to get an SSI/SSP Medi-Cal card and will then give you a card for the current month.

PLEASE READ THE REVERSE OF THIS FORM

YOUR RIGHT TO APPEAL THIS ACTION

If you are dissatisfied with the action described on the other side, or any other county action, you may request a state hearing before a hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your county worker can help you request a hearing. If you decide to request a hearing, you must do so **WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.**

A State hearing and aid paid pending described below will not be available if the only action you object to is an automatic change in your eligibility which is required by State or federal law. This denial of a State hearing is required by Title 22, C.A.C. Section 50951.

Aid Paid Pending

If you are now receiving Medi-Cal and ask for a state hearing before the effective date of this notice, you will delay the county's action, thus your Medi-Cal will continue until the hearing begins.

State Regulations Available

State Regulations, including those covering state hearings, are available at the local office of the county welfare department.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of Public Inquiry and Response Unit (800) 952-5253.

Information Practices Act Notice

The information you are asked to write in below is needed to process your request, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the record for decision and may locate this record by contacting Public Inquiry and

Response Unit (phone number shown above). Any information you provide may be shared with the county welfare department, with the U.S. Department of Health and Human Services, Authority: W/ 10950.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

**Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 19-36
Sacramento, CA 95814**

**Los Angeles County Residents send to:
Fair Hearing Section
P.O. Box 10280
Glendale, California 91209**

You may also request a hearing by calling the toll-free number of Public Inquiry and Response Unit.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

Teletypewriter (TTY) only: (800) 952-5434*

*You will have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

**Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814**

REQUEST FOR A STATE HEARING

Name _____ Phone Number _____
Address _____ City _____ State _____ Zip Code _____

I am requesting a State hearing because of an action by the welfare department of _____ county related to Medi-Cal.

Reasons for my request:

I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

Language _____ Dialect _____

State of California - Health and Welfare Agency
Department of Health Services
Medical Assistance

NOTICE PREPARATION DATE:
** A **

MEDI-CAL
NOTICE OF ACTION

DISCONTINUANCE OF SSI/SSP MEDI-CAL --
EXTENDED MEDI-CAL ELIGIBILITY

|

|

Social Security Number:
** C **

** B **

|

|

Beneficiary ID Number:
** D **

The Social Security Administration (SSA) has notified us that you are no longer eligible to receive a Supplementary Security Income/State Supplementary Payment (SSI/SSP) gold check. This means that you are no longer eligible for Medi-Cal as an SSI/SSP recipient. Because of this, you will not be eligible for an SSI/SSP Medi-Cal card after
____** J **____.

The regulations which require this action are California Administrative Code, Title 22, Sections 50227 and 50703.

Even though you will no longer be eligible for an SSI/SSP Medi-Cal card after
____** J **____, you may be eligible for Medi-Cal benefits under another Medi-Cal category. IF YOU ARE INTERESTED IN CONTINUING TO RECEIVE MEDI-CAL BENEFITS, COMPLETE THE APPLICATION AND MEDI-CAL TEMPORARY REDETERMINATION FORMS THAT ARE ATTACHED. Mail them IMMEDIATELY to the county welfare department at the following address:

|

|

** H **

|

|

If the forms are received by ____** I **____ and the information you provide on the forms is complete, the county will determine your continuing eligibility immediately.

The county will contact you to set up an appointment for a required face-to-face interview with your county eligibility worker after your continuing Medi-Cal only eligibility is determined for the first time.

If the forms do not provide complete information, the county will contact you for the necessary information. If you do not provide it, your Medi-Cal eligibility will end.

If you have questions on how to complete the forms or if you need help with them, contact the county at the address or phone number listed above.

If the forms are not returned by the date stated above, your continuing eligibility for Medi-Cal will not be determined and you will not be eligible for an SSI/SSP Medi-Cal card after ____** J **____.

If you ever want Medi-Cal again, you will have to make an application at the county welfare department.

MEDI-CAL NOTICE OF ACTION

DISCONTINUANCE OF SSI/SSP MEDI-CAL -- EXTENDED MEDI-CAL ELIGIBILITY

Page 2

Keep this letter to show the county welfare department. It will help them to determine your Medi-Cal status.

If you are still receiving an SSI/SSP gold check, you should contact your county welfare department. The county will verify with SSA that you should continue to get an SSI/SSP Medi-Cal card and will then give you a card for the current month.

PLEASE READ THE ENCLOSED REQUEST FOR FAIR HEARING

State of California - Health and Welfare Agency
Department of Health Services
Medical Assistance

NOTICE PREPARATION DATE:
** A **

MEDI-CAL DISCONTINUANCE OF SSI/SSP MEDI-CAL
NOTICE OF ACTION

1

1

Social Security Number:
** C **

** B **

1

1

Beneficiary ID Number:
** D **

The Social Security Administration (SSA) has notified us that you are no longer eligible to receive a Supplemental Security Income/State Supplementary Payment (SSI/SSP) gold check. Because of this, you will not be eligible for an SSI/SSP Medi-Cal card after ____** E **____.

The regulations which require this action are California Administrative Code, Title 22, Sections 50227 and 50703.

Even though you are no longer eligible for an SSI/SSP Medi-Cal card, you may still be eligible for Medi-Cal benefits under another Medi-Cal category. IF YOU ARE INTERESTED IN CONTINUING TO RECEIVE MEDI-CAL BENEFITS, COMPLETE THE APPLICATION AND STATEMENT OF FACTS FORMS THAT ARE ATTACHED. Mail them IMMEDIATELY to the county welfare department at the following address:

1

1

** H **

1

1

The county will contact you to set up an appointment for you to come in for an interview with a county worker. This interview and the completion of the forms are necessary to establish your ongoing Medi-Cal eligibility.

If you do not return the forms and participate in the interview, your Medi-Cal eligibility cannot be determined and your Medi-Cal benefits will end in the month shown above.

If you have questions on how to complete the forms, or if you need help with them, contact the county at the address or phone number listed above.

Keep this letter to show the county welfare department. It will help them to determine your Medi-Cal status.

If you are still receiving an SSI/SSP gold check, you should contact your county welfare department. The county will verify with SSA that you should continue to get an SSI/SSP Medi-Cal card and will then give you a card for the current month.

PLEASE READ THE ENCLOSED REQUEST FOR FAIR HEARING

State of California - Health and Welfare Agency
Department of Health Services
Medical Assistance

NOTICE PREPARATION DATE:
** A **

MEDI-CAL
NOTICE OF ACTION

DISCONTINUANCE OF SSI/SSP MEDI-CAL --
DECEASED PERSONS

To the Representatives of the Estate of:

| _____ |

** B **

| _____ |

Social Security Number:
** C **

Beneficiary ID Number:
** D **

The Social Security Administration has notified us of the death of the above-named person and that as a result, his/her Supplemental Security Income/State Supplementary Payment (SSI/SSP) gold check has been stopped. Because of this, the last month an SSI/SSP Medi-Cal card will be sent is ____** K **____.

This action is required by California Administrative Code, Title 22, Section 50176.

If the individual named above is not deceased, he/she has the right to request restoration of his/her SSI/SSP gold check and Medi-Cal card. You should contact your local Social Security Office. If you contact Social Security for this reason, also contact the Department of Social Services' Public Inquiry and Response Unit at the address or telephone number below regarding continued receipt of an SSI/SSP Medi-Cal card.

Public Inquiry and Response Unit
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Toll Free Number: 1-800-952-5253

For your information, there are no special death or burial benefits provided under the Medi-Cal program.

PLEASE READ THE ENCLOSED REQUEST FOR FAIR HEARING

State of California - Health and Welfare Agency
Department of Health Services
Medical Assistance

NOTICE PREPARATION DATE:
** A **

MEDI-CAL
NOTICE OF ACTION

DISCONTINUANCE OF SSI/SSP MEDI-CAL --
LOSS OF RESIDENCE

I

I

** B **

Social Security Number:
** C **

I

I

Beneficiary ID Number:
** D **

The Social Security Administration has notified us that you no longer live in California. As a result, you are no longer eligible to receive a State Supplementary Payment (SSP). Because of this, you will not be eligible for an SSI/SSP Medi-Cal card after
** E **.

The regulation which requires this action is California Administrative Code, Title 22, Section 50320, which specifies that a person must live in California in order to be eligible for Medi-Cal.

If you believe that the discontinuance of your SSI/SSP benefits was incorrect, contact your local Social Security Office. If you contact Social Security for this reason, also contact the Department of Social Services' Public Inquiry and Response Unit at the address or telephone number below regarding continued receipt of an SSI/SSP Medi-Cal card.

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State Department of Social Services
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Medical Assistance

NOTICE PREPARATION DATE:

** A **

MEDI-CAL
NOTICE OF ACTION

DISCONTINUANCE OF SSI/SSP MEDI-CAL --
LOSS OF CONTACT

** B **

Social Security Number:

** C **

Beneficiary ID Number:

** D **

The Social Security Administration has notified us that they have lost contact with you. As a result, you are no longer eligible to receive a Supplementary Security Income/State Supplementary Payment (SSI/SSP). Because of this, you will not be eligible for an SSI/SSP Medi-Cal card after ____** E **____.

The regulation which requires this action is California Administrative Code, Title 22, Section 50175, which specifies that eligibility shall be discontinued if there is loss of contact with a Medi-Cal beneficiary.

If you believe that the discontinuance of your SSI/SSP benefits was incorrect, contact your local Social Security Office. If you contact Social Security for this reason, also contact the Department of Social Services' Public Inquiry and Response Unit at the address or telephone number below regarding continued receipt of an SSI/SSP Medi-Cal card.

Public Inquiry and Response Unit
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

Toll Free Number: 1-800-952-5253

PLEASE READ THE ENCLOSED REQUEST FOR FAIR HEARING

READ INSTRUCTIONS ON BACK BEFORE COMPLETING.

Only medical expenses in the following month may be listed below:

A

Mo. Yr.

Share of Cost

The amount that you must pay or obligate is:

B

Page 01

Retro Elig?

(Yes/No)

NTY CODE

Medical expenses of family members listed below may be used to meet Share of Cost

State Number				Name - Last, First		B	A	Birthdate			Sex	Other Cov Code	Social Security No	HIC or RR No.
Aid	7 Digit Serial No	FBU	Pers					Mo.	Day	Yr.				
	D													

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will neither claim nor accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".
I understand that the amount to be reimbursed by insurance or any other third party for the service rendered cannot be listed on this form.
I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

PROVIDER NAME	PROVIDER NO.	DATE OF SERVICE			SERVICE	PROC CODE/ PRESC. NO.	TOTAL BILL	BILLED PATIENT	BILLED MEDI-C
		MO	DAY	YR			\$	\$	\$
PATIENT NAME									
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)									
PROVIDER NAME	PROVIDER NO.								
PATIENT NAME									
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)									
PROVIDER NAME	PROVIDER NO.								
PATIENT NAME									
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)									
PROVIDER NAME	PROVIDER NO.								
PATIENT NAME									
PROVIDER SIGNATURE (SEE DECLARATION ABOVE)									

I have read the instructions on the back of this form. I agree to assume full legal responsibility for amounts listed above in the "Billed Patient" column.

X

SIGNATURE OF APPLICANT

DATE

YOUR RIGHT TO APPEAL THIS ACTION

-14-

If you are dissatisfied with the action described on the attached notice, you may request a state hearing before a hearing Officer of the State Department of Social Services. This hearing will be conducted in an informal manner to assure that you are present is able to speak freely.

If you decide to request a hearing, you must do so WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.

Paid Pending

If you are now receiving Medi-Cal and ask for a state hearing before the effective date of this action, your Medi-Cal will continue until the hearing.

State Regulations Available

State Regulations, including those covering state hearings, are available at the local office of the county welfare department.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney or any other person, but you are expected to arrange for the representative yourself. You can get help locating free legal assistance by calling the toll-free number of Public Inquiry and Response Unit (800) 952-5253.

Information Practices Act Notice

The information you are asked to write in below is needed to process your request, and processing may be delayed if your request is incomplete. A case file will be set up by the Chief Referee. You have a right to examine the materials that make up the record for decision and may locate this record by contacting Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the county welfare department, with the State Department of Health and Human Services, Authority: W&IC 950.

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Office of Chief Referee
State Department of Social Services
744 P Street, Mail Station 6-100
Sacramento, CA 95814

You may also request a hearing by calling the toll-free number of Public Inquiry and Response Unit.

Public Inquiry and Response (Public Information)

Toll-Free Number: (800) 952-5253*

Teletypewriter (TTY) only: (800) 952-5434*

*You will have to dial "1" first.

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights or files. Assistance is also available in some languages other than English, including Spanish. You may phone, write, or come in.

Public Inquiry and Response
State Department of Social Services
744 P Street, Mail Station 16-23
Sacramento, CA 95814

REQUEST FOR A STATE HEARING (RAMOS)

Name	Phone Number
Address	City
	State
	Zip Code

I am requesting a State hearing because of an action taken by the State of California related to Medi-Cal.

Reasons for my request:

If I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

Disposition of Ramos vs. Myers Cases

TO: Department of Health Services
Medi-Cal Eligibility Branch
714 P Street, Room 1692
Sacramento, CA 95814

Attention: Operations Unit, MST

County _____

Month/Year of Eligibility _____ / _____
Month Year

- | | 1 month | 2 months | 3 months |
|--|---------|----------|----------|
| 1. Number of individuals who returned MC 211 timely. | | | |
| 2. Number of individuals who did not return the MC 211 timely but did return form within the same month. | | | |
| 3. Number of individuals receiving one, two, or more months of additional continued no cost or state determined share-of-cost Medi-Cal as the result of delayed county eligibility determination | | | |

MEDI-CAL TEMPORARY REDETERMINATION

Name					First		Middle		Last		COUNTY USE ONLY State No.				
Home Address					Street					City			Zip Code		
Billing Address (if different)										Telephone Number					

3. List all persons regularly living in your household (include persons absent due to hospitalization or solely because of school).

Name	Social Security Number	Sex M/F	Birthdate Mo./Day/Yr.	Relationship To You

If not enough room, list additional members of your household on page 4.

COMPLETE THE FOLLOWING INFORMATION FOR YOURSELF, YOUR SPOUSE, IF HE/SHE IS LIVING WITH YOU, AND ANY OF YOUR CHILDREN YOU LISTED IN 3 WHO ARE UNDER 21 AND HAVE NEVER BEEN MARRIED.

4. Is anyone currently receiving a cash grant or Medi-Cal? Yes ☐ No ☐ If yes,

Name(s)	Cash Grant		Medi-Cal Only	
	Yes	No	Yes	No

5. Complete the following about your living arrangements:

☐ Rent a room, apartment, house or trailer.
☐ Pay for room and board.
☐ Receive free room.
☐ Receive free room and board.
☐ Live in a board and care facility.
☐ Live in a nursing home or hospital.
☐ Live in a home, trailer, mobile home, boat, or motor vehicle you own or are buying.

Do you own any real property (land, buildings) which you do not now live in?
 Yes ☐ No ☐ If yes,

Full value (from tax statement) \$ _____ Amount owed \$ _____
 Yearly income from property \$ _____
 List yearly expenses on property (including interest payments, taxes, assessments, utilities, insurance, and upkeep and repairs) on page 4.

7. Do you and/or your spouse and/or children have any of the following property?

Item	Yes	No	Person Who Owns Property	Amount (or Market Value)	Amount Owed
Cash or money on hand or in the house					
Bank account					
Bank account					
Bank account					
Checks or money in a safe deposit box or being held for you					
Stocks or bonds					
Notes, mortgages, trust deeds, sales contracts					
Motor vehicle					
Motor vehicle					
Boat, camper, trailer					
Burial reserve or trust					
Burial reserve or trust					
Burial plots for other than family members					
Jewelry over \$100.					
Business equipment, tools, inventory (list on page 4)					

8. Do you and/or your spouse and/or children have life insurance? Yes ☐ No ☐
If yes, complete for each policy:

Person Insured	Owner of Policy	Face Value	Current Cash Value

9. Do you and/or your spouse and/or children have Medicare coverage? Yes ☐ No ☐ If yes,

Person Covered	Medicare Number	Premium Deducted From Check
		Yes <input type="checkbox"/> No <input type="checkbox"/>
		Yes <input type="checkbox"/> No <input type="checkbox"/>

10. Do you and/or your spouse and/or children have health or hospitalization insurance?
 Yes ☐ No ☐ If yes,

Person(s) Insured	Type of Insurance	Monthly Premium Paid
		\$
		\$

11. Do you and/or your spouse and/or children receive any of the following types of income?

Type	Yes	No	Person Receiving Income	Monthly Amount
a. Cash grant				\$
b. Social Security				\$
c. Pension or retirement				\$
d. Unemployment				\$
e. Disability insurance				\$
f. V.A. benefits				\$
g. Child support or alimony				\$
h. Interest income or dividends				\$
i. Other (list)				\$

12. Do you and/or your spouse and/or children have earned income? Yes ☐ No ☐
 If yes,

Person Employed	How Often Paid	Days A Week Worked	Gross Income Per Pay Period	Expenses (list on page 4) (Include Taxes, Child Care, And Other Deductions From Check)	Total Miles To/From Work
			\$	\$	
			\$	\$	
			\$	\$	

13. Are you and/or your spouse and/or children self-employed? Yes ☐ No ☐

If yes, will income this year be the same as last year? Yes ☐ No ☐

If yes, attach copy of last year's tax statement

If no, attach copy of business records showing current income, expenses, etc.

14. Do you and/or your spouse pay child support or alimony under a court order or based on an agreement with the District Attorney? Yes ☐ No ☐ If yes,

Amount paid \$ _____ To whom _____

5. Additional information (identify additional information for other pages by question number)

- I realize that if I deliberately make false statements or withhold information, I (or the person on whose behalf I am acting) may lose Medi-Cal eligibility and/or I may be prosecuted for fraud.*

E.W.

Date _____